

**AUTHORIZATION TO RELEASE DENTAL INFORMATION**

*(The execution of this form does not authorize the release of information other than that specifically described below)*

# TO: RELEASE TO:

Patient Name:

DOB:

I request and authorize the above‐named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes the following information:

# INFORMATION REQUESTED: DATES COVERED:

 Copy of complete dental chart All treatment rendered in this office or by this doctor

 Copy of dental x‐rays Limited to treatment dates for conditions described below:

 Other (e.g. models∙ describe)

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

 Transfer of records Second Opinion

 Other

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any

event: on (date supplied by patient); or if revoked in writing by patient; or 180

days from the date hereof; or under the following conditions:

# OTHER CONDITIONS: A copy of this authorization or my signature thereon: \_x\_ may, may not be used with the same effectiveness as an original.

PERSON AUTHORIZED TO SIGN FOR

PATIENT NAME (print) PATIENT:

PATIENT SIGNATURE

DATE State How Authorized